CBAS Stakeholder Workgroup Recommendations – Summary (Including 3/6/14 Meeting Additions)
Update for Olmstead Advisory Committee – March 19, 2014

Workgroup Recommendation	DHCS/CDA Concurrence[i]		
	Yes	No	Undetermined
1. Delete provisions related to ADHC to CBAS transition that are no longer relevant, including enhanced case management.	✓		
2. Continue access monitoring and streamline **reporting** requirements to Centers for Medicare & Medicaid Services (CMS).	✓		
3. Create new Specials Terms and Conditions (STC)/Standards of Participation (SOP) section(s) for Plan/provider relationships – include: • selective contracting per provider quality and Plan credentialing standards • flexibility for Plans to arrange CBAS provider payment based on participant level of acuity and scope of services • liaison and care plan collaboration • timelines for eligibility determinations and service authorization • discharge planning and reporting 03/06 Meeting Additions: STCs to express the intent that access to quality CBAS centers be maintained.	✓		
4. Retain language for fee-for-service (FFS) **grievances and appeals.**	✓		

CBAS Stakeholder Workgroup Recommendations – Summary (Including 3/6/14 Meeting Additions)
Update for Olmstead Advisory Committee – March 19, 2014

Workgroup Recommendation	DHCS/CDA Concurrence[i]		
	Yes	No	Undetermined
5. Allow more Plan discretion regarding conducting face-to-face **eligibility determination** – should be driven by beneficiary's clinical status and provide for expediting of enrollment. 03/06 Meeting Additions: STCs to include intent language about plans cooperating with each other to ensure continuity of care when individuals switch health plans. STCs regarding eligibility determination should be clear that plans have discretion to do/not do face-to-face eligibility determination when a Health Risk Assessment is already done or an individual is otherwise determined eligible.	✓		
6. Allow **authorization for up to 12 months**, based on clinical status.	✓		
7. Individual Plan of Care (**IPC**) to be redesigned. STC/SOP references revised to reflect Plan/provider collaboration on care planning to incorporate larger managed care plan participant care goals beyond CBAS.	✓		
8. Include references to "**care coordination**" that CBAS centers are required to provide per ADHC nursing and social services regulations.	✓		
9. Revise language describing **basic CBAS benefits** and service components to be clearer and reflect statutory/regulatory requirements (e.g., transportation definition, CBAS relationship to behavioral health, etc.).	✓		

CBAS Stakeholder Workgroup Recommendations – Summary (Including 3/6/14 Meeting Additions)
Update for Olmstead Advisory Committee – March 19, 2014

Workgroup Recommendation	DHCS/CDA Concurrence[i]		
	Yes	No	Undetermined
10. Access - Allow planned growth of new CBAS centers 03/06 Meeting Additions: Criteria for determining need should include consideration of fee-for-service participant needs as well as managed care need.	✓		
11. Retain unbundled services 03/06 Meeting Additions: STCs should include intent language that addresses the plans' responsibility when there is an absence of a CBAS center and there are individuals who would be eligible. Specifically, plans should focus on coordinating delivery of services with the objective of supporting the individual's ability to live in a community setting.	✓	✓	
12. Revise quality assurance requirements in STCs and further develop quality metrics for provider quality of care standards to add to the **quality strategy.**	✓		

CBAS Stakeholder Workgroup Recommendations – Summary (Including 3/6/14 Meeting Additions)
Update for Olmstead Advisory Committee – March 19, 2014

Workgroup Recommendation	DHCS/CDA Concurrence[i]		
	Yes	No	Undetermined
13. Rates: • allow Plans to pay CBAS providers based on acuity • restore rate to the level pre-2011 10% rate reduction • establish base rates for Plans and providers based on formula that more accurately reflects CBAS eligibility and program requirements rather than ADHC historical rates pre-Settlement.	✓	✓	
14. Add statutory references to SOPs.	✓		
15. Delete non-profit provider provisions.	✓		
16. Give **CDA authority to grant program flexibility** for which the California Department of Public Health currently has authority licensing statutes and regulations.			✓
17. Create mechanism for **payment for a day of services that is less than the 4 hours** required by regulation. Exceptions could be defined such as participant level of acuity or emergent non-medical issues (e.g., fire, flood, earthquake, tornado, etc.)			✓
18. Revise language regarding staffing requirements to clarify how the regulatory standard for average daily attendance in the previous quarter will be applied.			✓

[i] Special Terms and Conditions (STC) are CBAS provisions in the 1115 Waiver document that define the CBAS benefit. Standards of Participation (SOP) are program standards that providers must meet to be certified as a CBAS Medi-Cal waiver provider. All STC/SOP changes are subject to negotiation with CMS.